10-13 Year Old AHCCCS EPSDT Tracking Form

Date: | Last Name: | First Name: | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number: | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	**Temp:**
OD	**Pulse:**
OS	**Resp:**
OU	**BP**
Corrected / uncorrected	**BP elevated?**

Dental Screen: Date of last exam: Next appt: Routine Urgent Parent advised

Nutritional Screen: Adequate Inadequate Supplements:

Hearing Screen: Within normal limits? Yes No **Speech:** Within normal limits? Yes No

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes No

If suspicious, specific objective testing performed

Behavioral Screen: Age appropriate? (HEADDSS, GAPS, parental interview) Yes No

PHYSICAL EXAM

Are the following normal?	**Yes**	**No**	**Describe abnormal findings:**
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary/Breast **Tanner Stage**			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test

(perform if at risk)

ADDITIONAL LABS ORDERED:

Hgb/Hct

Lipid profile

Urinalysis

Other

Confidential Documentation:

See attached note please

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** **No** **Delayed?** **Deferred?**

Given today? **Hep B** **Td** **MMR** **Influenza** **Varicella** **Hep A** **Other**

ANTICIPATORY GUIDANCE

- Drowning/sun safety
- Seat belts/air bags
- Sports/injury prevention
- Nutrition/exercise
- Dental/flossing/self care
- Sex education
- Self control
- Peer refusal skills
- Social interaction
- Depression/anxiety
- Tobacco/alcohol/drugs/inhalants
- Violence prevention/gun safety
- Education goals/activities
- "Safe at Home?"
- Parenting advice
- Family involvement
- Next appointment

REFERRALS:

Behavioral **Dental** **Nutritional** **WIC** **Developmental** **Specialty** **Other**

Yes No

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004